		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035204

Facility Name: Rosewood Care Center of East Peoria

Address: 900 Centennial Drive (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 699-5400 **Fax #** ( )

IDPA ID Number: 431446788001

Date of Initial License for Current Owners: 4/18/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code		X	Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2004 to 6/30/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,264	8,264	8
9	SNF/PED					9
10	ICF	13,244	10,700		23,944	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,244	10,700	8,264	32,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.53%

D. How many bed-hold days during this year were paid by the Department?
23 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/19/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/19/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 8,264

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 6/30/2005 Fiscal Year: 6/30/2005

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	179,940	14,660	8,379	202,979		202,979		202,979			1
2	Food Purchase		166,472		166,472		166,472	(12,422)	154,050			2
3	Housekeeping	120,554	30,303		150,857		150,857		150,857			3
4	Laundry	38,556	13,110		51,666		51,666		51,666			4
5	Heat and Other Utilities			99,367	99,367		99,367	4	99,371			5
6	Maintenance	15,094	9,110	122,084	146,288		146,288	(2,520)	143,768			6
7	Other (specify):* Sanitation			8,860	8,860		8,860		8,860			7
8	**TOTAL General Services**	354,144	233,655	238,690	826,489		826,489	(14,938)	811,551			8
	B. Health Care and Programs											
9	Medical Director			25,282	25,282		25,282		25,282			9
10	Nursing and Medical Records	1,765,270	129,800	39,426	1,934,496		1,934,496		1,934,496			10
10a	Therapy	75,415	5,215	440,629	521,259		521,259	(11,141)	510,118			10a
11	Activities	45,773	3,814	2,500	52,087		52,087		52,087			11
12	Social Services	41,793		2,500	44,293		44,293		44,293			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,928,251	138,829	510,337	2,577,417		2,577,417	(11,141)	2,566,276			16
	C. General Administration											
17	Administrative			396,800	396,800		396,800	(243,143)	153,657			17
18	Directors Fees											18
19	Professional Services			3,885	3,885		3,885	30,810	34,695			19
20	Dues, Fees, Subscriptions & Promotions			25,763	25,763	1,990	27,753	(9,618)	18,135			20
21	Clerical & General Office Expenses	144,701	33,302	13,101	191,104		191,104	117,940	309,044			21
22	Employee Benefits & Payroll Taxes			292,907	292,907		292,907	26,217	319,124			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,447	3,447	(1,990)	1,457		1,457			24
25	Other Admin. Staff Transportation			7,714	7,714		7,714	13,749	21,463			25
26	Insurance-Prop.Liab.Malpractice			64,105	64,105		64,105	15,656	79,761			26
27	Other (specify):*											27
28	**TOTAL General Administration**	144,701	33,302	807,722	985,725		985,725	(48,389)	937,336			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,427,096	405,786	1,556,749	4,389,631		4,389,631	(74,468)	4,315,163			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Center of East Peoria #0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			14,101	14,101		14,101	159,281	173,382			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							466,998	466,998			32
33	Real Estate Taxes			66,180	66,180		66,180		66,180			33
34	Rent-Facility & Grounds			1,083,736	1,083,736		1,083,736	(1,072,686)	11,050			34
35	Rent-Equipment & Vehicles			43,168	43,168		43,168		43,168			35
36	Other (specify):* **Mortgage Insur.**							51,184	51,184			36
37	**TOTAL Ownership**			1,207,185	1,207,185		1,207,185	(395,223)	811,962			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		226,992	25,489	252,481		252,481		252,481			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		226,992	91,189	318,181		318,181		318,181			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,427,096	632,778	2,855,123	5,914,997		5,914,997	(469,691)	5,445,306			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,148)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,184)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(274)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,533)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,462)	20		28
29	Other-Attach Schedule Marketing Salary	(67,360)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (95,961)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(373,730)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (373,730)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (469,691)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Rosewood Care Center of East Peoria

ID# 0035204

Report Period Beginning: 7/1/2004

Ending: 6/30/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$ (67,360)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(67,360)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Rosewood Care Center of East Peoria **#** 0035204 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,422)	0	0	0	0	0	0	0	0	0	0	(12,422)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4	0	0	0	0	0	0	0	0	4	5
6	Maintenance	0	(27,755)	25,235	0	0	0	0	0	0	0	0	(2,520)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,422)	(27,755)	25,239	0	0	0	0	0	0	0	0	(14,938)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(11,141)	0	0	0	0	0	0	0	0	0	(11,141)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(11,141)	0	0	0	0	0	0	0	0	0	(11,141)	16
	C. General Administration													
17	Administrative	0	(396,800)	153,657	0	0	0	0	0	0	0	0	(243,143)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	30,810	0	0	0	0	0	0	0	0	30,810	19
20	Fees, Subscriptions & Promotions	(9,995)	0	377	0	0	0	0	0	0	0	0	(9,618)	20
21	Clerical & General Office Expenses	(67,360)	0	185,300	0	0	0	0	0	0	0	0	117,940	21
22	Employee Benefits & Payroll Taxes	0	0	26,217	0	0	0	0	0	0	0	0	26,217	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	13,749	0	0	0	0	0	0	0	0	13,749	25
26	Insurance-Prop.Liab.Malpractice	0	6,659	8,997	0	0	0	0	0	0	0	0	15,656	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(77,355)	(390,141)	419,107	0	0	0	0	0	0	0	0	(48,389)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(89,777)	(429,037)	444,346	0	0	0	0	0	0	0	0	(74,468)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Rosewood Care Center of East Peoria **#** 0035204 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	142,450	16,831	0	0	0	0	0	0	0	0	159,281	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,184)	473,182	0	0	0	0	0	0	0	0	0	466,998	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,083,736)	11,050	0	0	0	0	0	0	0	0	(1,072,686)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	51,184	0	0	0	0	0	0	0	0	0	51,184	36
37	**TOTAL Ownership**	(6,184)	(416,920)	27,881	0	0	0	0	0	0	0	0	(395,223)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(95,961)	(845,957)	472,227	0	0	0	0	0	0	0	0	(469,691)	45

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	$ 396,800	HSM Management Services, Inc.	100.00%	$	$ (396,800)	1
2	V	6	Repairs & Maintenance	27,755	HSM Management Services, Inc.	100.00%		(27,755)	2
3	V								3
4	V	10a	Therapy	440,629	Rosewood Therapy Services, Inc.	0.00%	429,488	(11,141)	4
5	V								5
6	V	34	Rent	1,083,736	East Peoria Real Estate, Inc.	0.00%		(1,083,736)	6
7	V	30	Depreciation		East Peoria Real Estate, Inc.	0.00%	142,450	142,450	7
8	V	32	Interest		East Peoria Real Estate, Inc.	0.00%	473,182	473,182	8
9	V	36	Mortgage Insurance		East Peoria Real Estate, Inc.	0.00%	51,184	51,184	9
10	V	26	Property Insurance		East Peoria Real Estate, Inc.	0.00%	6,659	6,659	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,948,920			$ 1,102,963	$ * (845,957)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	See Schedule VIII	$	HSM Management Services, Inc.	100.00%	$ 4	$ 4	15
16	V		17	See Schedule VIII		HSM Management Services, Inc.	100.00%	153,657	153,657	16
17	V		21	See Schedule VIII		HSM Management Services, Inc.	100.00%	185,300	185,300	17
18	V		22	See Schedule VIII		HSM Management Services, Inc.	100.00%	26,217	26,217	18
19	V		25	See Schedule VIII		HSM Management Services, Inc.	100.00%	13,749	13,749	19
20	V		30	See Schedule VIII		HSM Management Services, Inc.	100.00%	16,831	16,831	20
21	V		34	See Schedule VIII		HSM Management Services, Inc.	100.00%	11,050	11,050	21
22	V		19	See Schedule VIII		HSM Management Services, Inc.	100.00%	30,810	30,810	22
23	V		26	See Schedule VIII		HSM Management Services, Inc.	100.00%	8,997	8,997	23
24	V		6	See Schedule VIII		HSM Management Services, Inc.	100.00%	25,235	25,235	24
25	V		20	See Schedule VIII		HSM Management Services, Inc.	100.00%	377	377	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 472,227	$ * 472,227	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Larry Vander Maten	President	Management	75.00%	1,153,916	2	5.47%	Salary	$ 66,814	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	474,809	2	5.47%	Salary	27,492	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 94,306		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	87,014,347	18	$ 1,723,032	$ 1,723,032	4,762,543	$ 94,306	1
2	21	Salaries - Others	Total Cost	87,014,347	18	2,976,309	2,976,309	4,762,543	162,902	2
3	22	Payroll Taxes	Total Cost	87,014,347	18	298,975		4,762,543	16,364	3
4	22	Employee Benefits	Total Cost	87,014,347	18	103,243		4,762,543	5,651	4
5	25	Travel	Total Cost	87,014,347	18	249,076		4,762,543	13,633	5
6	30	Depreciation	Total Cost	87,014,347	18	307,518		4,762,543	16,831	6
7	34	Building Rent	Total Cost	87,014,347	18	201,898		4,762,543	11,050	7
8	19	Professional Services	Total Cost	87,014,347	18	562,909		4,762,543	30,810	8
9	21	Telephone	Total Cost	87,014,347	18	173,318		4,762,543	9,486	9
10	26	Insurance	Total Cost	87,014,347	18	164,374		4,762,543	8,997	10
11	21	Taxes, Licenses, & Office Supplies	Total Cost	87,014,347	18	235,903		4,762,543	12,912	11
12	6	Maintenance	Total Cost	87,014,347	18	157,822		4,762,543	8,638	12
13	5	Heat & Other Utilities	Total Cost	87,014,347	18	77		4,762,543	4	13
14	20	Dues & Subscriptions	Total Cost	87,014,347	18	6,896		4,762,543	377	14
15	17	Direct - Admin	Direct Cost	1	1	59,351	59,351	1	59,351	15
16	17	Direct - Admin	Direct Cost	17	17	1,096,595	1,096,595	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	4,202		1	4,202	17
18	22	Direct - Payroll Taxes	Direct Cost	17	17	78,520		0	0	18
19	30	Direct - Depreciation	Direct Cost	1	0	0		1	0	19
20	30	Direct - Depreciation	Direct Cost	2	2	1,050		0	0	20
21	25	Direct - Travel	Direct Cost	1	1	116		1	116	21
22	25	Direct - Travel	Direct Cost	6	6	932		0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	16,597		1	16,597	23
24	6	Direct - Maintenance	Direct Cost	14	14	214,814		0	0	24
25	TOTALS					$ 8,633,527	$ 5,855,287		$ 472,227	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial Mort.		X	Mortgage	$53,553.68	10/01/03	$ 10,665,100	$ 10,468,049	11/1/38	4.96%	$ 522,468	1
2	Less: Interest Income Offset										(6,184)	2
3	Less: Related Party Interest Income Offset										(51,178)	3
4	Amortization of Loan Fees										3,098	4
5	Real Estate Company Interest Income										(1,206)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$53,553.68		$ 10,665,100	$ 10,468,049			$ 466,998	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,665,100	$ 10,468,049			$ 466,998	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 51,184** **Line # 36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Rosewood Care Center of East Peoria **#** 0035204 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 65,218	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 65,105	2
3. Under or (over) accrual (line 2 minus line 1).	$ (113)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 66,293	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 66,180	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	61,273	8
2001	68,281	9
2002	63,027	10
2003	64,572	11
2004	65,637	12

2003 Payment = $32,286

2004 Payment = $32,819

Accrual = Balance of 2004 tax bill (32,818) and 1/2 of estimated 2005 tax bill (33,475)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of East Peoria COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0035204

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-01-24-100-024	900 Centenial Drive	$ 65,636.80	$ 63,636.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 65,636.80	$ 63,636.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,125 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	301,000	1988	$ 77,830	1
2					2
3	TOTALS	301,000		$ 77,830	3

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1989	$ 2,953,579	$	10-25	$ 117,446	$ 117,446	$ 2,136,599	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements - Original Construction			1989	209,624		15-25	7,165	7,165	163,104	9
10	Fence			1990	2,377		25	95	95	1,330	10
11	Concrete Work			1991	5,190		25	208	208	2,912	11
12	Painting			1992	7,694		5			7,694	12
13	Irrigation System			1993	10,175		25	407	407	4,918	13
14	Generator			1989	14,937		10			14,937	14
15	Signs			1989	3,157		10			3,157	15
16	Walk-In Cooler			1989	5,770		20	288	288	4,694	16
17	Sinks			1989	3,744		10			3,744	17
18	Exhaust Hood			1989	4,621		10			4,621	18
19	Fire System			1989	1,271		20	63	63	1,038	19
20	Carpeting			1989	10,368		10			10,368	20
21	Cubicle Track			1989	6,294		10			6,294	21
22	Door Installation			1991	2,750		10			2,750	22
23	Sprinkler Addition			1992	786		10			786	23
24	Ceramic Sink			1994	2,011		10	68	68	2,011	24
25	Parking Lot Extension			2003	37,489		25	1,500	875	2,375	25
26	Shingle Roof Replacement			2004	97,105		10	6,474	6,474	6,474	26
27											27
28											28
29											29
30	Leasehold Improvements - Facility:										30
31	Carpeting			1994	3,238		7			3,238	31
32	Painting, Baseboard Stripping, Drapery, Tile, Carpet			1995	37,083		7			37,083	32
33	Painting/Tiling			1996	3,960		7			3,960	33
34	Wallpaper			1998	3,525	378	7	378		3,525	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Floor Covering/Wallpaper/Plants	1998	$ 18,546	$ 2,649	7	$ 2,649	$	$ 17,697	37
38	Mini Blinds/Wallcovering	1999	5,486	784	7	784		4,910	38
39	Carpeting	1999	4,375	625	7	625		3,646	39
40	Computer Cabling	2000	2,392	341	7	341		1,565	40
41	Computer Receptacles	2001	214	31	7	31		136	41
42	Doors	2001	5,966	852	7	852		3,623	42
43	Parking Lot	2001	11,475	1,639	7	1,639		6,831	43
44	Drapes, Wallcoverings, Head Wallcoverings	2001	27,188	3,884	7	3,884		15,118	44
45	Drapery	2003	1,237	177	7	177		428	45
46	Painting	2003	3,112	444	7	444		1,035	46
47	Flooring	2005	3,491	125	7	125		125	47
48									48
49									49
50	Leasehold Improvements - Management Company:								50
51	Office Construction/Improvements	1995	419		5			419	51
52	Office Design	1995	38		5			38	52
53	Office Shelving	1996	89		4			89	53
54	Office Expansion	1996	396		4			396	54
55	Office Expansion	1997	1,059		3			1,059	55
56	Office Expansion	1998	597		3			597	56
57	Office Addition	1999	295		3			295	57
58	Door Locks	1999	147		3			147	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,513,270	$ 11,929		$ 145,643	$ 133,089	$ 2,485,766	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 158,288	$ 2,172	$ 19,452	$ 17,280	5-10 Yrs	$ 111,327	71
72	Current Year Purchases	26,012		512	512	5-10 Yrs	512	72
73	Fully Depreciated Assets	413,841					413,841	73
74								74
75	TOTALS	$ 598,141	$ 2,172	$ 19,964	$ 17,792		$ 525,680	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	$ 34,981	$	$ 7,775	$ 7,775	4	$ 16,027	76
77										77
78										78
79										79
80	TOTALS			$ 34,981	$	$ 7,775	$ 7,775		$ 16,027	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,224,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 14,101	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 173,382	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 159,281	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,027,473	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

N/A - ONLY HIRE CERTIFIED AIDES
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs	$	19,471	$	238,742	$	19,471	$ 238,742	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,428		3,522		1,428	3,522	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a-8	hrs		18,268		187,224	5,215	18,268	192,439	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-8	# of prescrpts					200,845		200,845	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Ambulance, Laboratory, Enterals Other (specify): I.V. Therapy, X-Ray	39-8					25,489	26,147		51,636	13
14	TOTAL			$	39,167	$	454,977	$ 232,207	39,167	$ 687,184	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (162,685)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 95,000)	777,094		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,856		6
7	Other Prepaid Expenses	3,434		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 633,699	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	142,611		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(110,577)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 32,034	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 665,733	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 185,261	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,866		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,250		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,293		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,500		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 444,170	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 444,170	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 221,563	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 665,733	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 215,459	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 215,459	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	162,104	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(156,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 6,104	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 221,563	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,286,013	1
2	Discounts and Allowances for all Levels	(1,865,928)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,420,085	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,738,719	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,738,719	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,687	13
14	Non-Patient Meals	12,148	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 16,835	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,184	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,184	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	278	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 278	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,182,101	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	826,489	31
32	Health Care	2,577,417	32
33	General Administration	985,725	33
	B. Capital Expense		
34	Ownership	1,207,185	34
	C. Ancillary Expense		
35	Special Cost Centers	252,481	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,914,997	40
41	**Income before Income Taxes (line 30 minus line 40)****	267,104	41
42	**Income Taxes**	(105,000)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 162,104	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,012	2,120	$ 67,291	$ 31.74	1
2	Assistant Director of Nursing	1,707	1,799	43,623	24.25	2
3	Registered Nurses	16,954	17,862	431,613	24.16	3
4	Licensed Practical Nurses	17,608	18,551	360,580	19.44	4
5	CNAs & Orderlies	66,811	70,389	796,854	11.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,891	4,099	75,415	18.40	8
9	Activity Director					9
10	Activity Assistants	4,969	5,235	45,773	8.74	10
11	Social Service Workers	3,801	4,004	41,793	10.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,461	20,503	179,940	8.78	15
16	Dishwashers					16
17	Maintenance Workers	1,410	1,486	15,094	10.16	17
18	Housekeepers	14,238	15,000	120,554	8.04	18
19	Laundry	5,144	5,420	38,556	7.11	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,839	12,473	144,701	11.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,718	4,971	65,309	13.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,563	183,912	$ 2,427,096 *	$ 13.20	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	40	$ 8,379	1-3	35
36	Medical Director	Contract	25,282	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	140	2,500	11-3	44
45	Social Service Consultant	140	2,500	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	320	$ 38,661		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	517	$ 14,610	10-3	50
51	Licensed Practical Nurses	737	24,816	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,254	$ 39,426		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ruth Swift	Administrator	0.00	$ 50,245
Julie Schmidgall	Administrator	0.00	9,106
Total Direct Administrator Cost from HSM Mgmt, line 17, col. 7			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,351

B. Administrative - Other

Description	Amount
Management Fees	$ 396,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 396,800

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 3,835
	Legal Fees	50
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 3,885

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,996
Unemployment Compensation Insurance	45,923
FICA Taxes	183,247
Employee Health Insurance	9,361
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Tuition Reimbursements	671
Employee Physicals	2,850
Employee Uniforms	595
Employee Relations	2,264
Management Company Allocations	26,217
TOTAL (agree to Schedule V, line 22, col.8)	$ 319,124

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	7,654
Health Care Worker Background Check (Indicate # of checks performed 76)	1,066
Promotional Advertising	6,995
Misc. Dues & Subscriptions	7,048
Management Company Allocations	377
Less: Public Relations Expense	(108)
Non-allowable advertising	(3,425)
Yellow page advertising	(3,462)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,135

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,457
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,457

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Schedule - Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria **#** 0035204 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $6,869**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **50,145** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **12,148**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER OF EAST PEORIA, INC.
RECLASSIFICATIONS
MEDICAID COST REPORT
6/30/05

	AMOUNT	LN #
A		
TRAVEL & SEMINARS	(1,990)	24
DUES, SUBSCRIPTIONS & PROMOTIONS	1,990	20
TO RECLASS IDPH LICENSE		

ROSEWOOD CARE CENTER OF EAST PEORIA, INC.
IDPH ID #0035204
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2005

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	$	7,714
	$	7,714

**ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS SUBMITTED WHICH WERE LESS THAN $250.00 EACH

ROSEWOOD CARE CENTER OF EAST PEORIA, INC.
IDPH ID #0035204
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2005

RELATED NURSING HOME:	CITY:
ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:	TYPE OF BUSINESS:
HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
EAST PEORIA REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY